Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NUEVA VIDA BEHAVIORAL HEALTH ASSOCIATES
5555 FREDERICKSBURG ROAD #102
SAN ANTONIO TX 78229

Respondent Name
LEONARD FAMILY CORP

Carrier's Austin Representative Box
Number 16

MFDR Tracking Number
M4-13-0320-01

MFDR Date Received
October 1, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…The claim was denied based on '2 other psychological interviews done.' The date of service being denied for payment is 02/28/11[sic]. This date of service was performed within the authorized timeframe and was denied in error…This was the first evaluation with us and did not require preauthorization."

Amount in Dispute: $660.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier denied the provider's request for reimbursement because this was the third psychiatric interview the injured worker has undergone for this claim. Since this was the third psychiatric interview, the provider was required to obtain pre-authorization prior to providing the services. The carrier denied a pre-authorization request on 2/23/12 prior to the services being rendered by the provider. Nonetheless, the provider went forward with its services…The carrier asserts that it has reviewed the medical bill according to applicable fee guidelines and rules. All reductions of the disputed charges were appropriately made."

Response submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 28, 2012	90801	$660.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 amended to be effective May 31, 2012, *37 Texas Register 3833*, applicable to medical fee dispute resolution requests filed on or after June 1, 2012, sets out the procedures for resolving a medical fee dispute.

2. 28 Texas Administrative Code §134.600 amended to be effective May 2, 2006, defines the health care requiring preauthorization.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanations of benefits (EOB)
   - 197 – payment denied/reduced for absence of precertification/preauthorization
   - 193 – Original payment decision is being maintained. Upon review it was determined that this claim was processed properly
   - Note: precert 1107924F0 denied on 2/22/12 there has been 2 other psychological interviews done

Issues

1. Did the respondent support its denial reason of "197 - payment denied/reduced for absence of precertification/preauthorization"?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (8) all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or Division exempted return-to-work rehabilitation program."
   The requestor requested preauthorization; however, the respondent submitted documentation to support that the preauthorization request was denied as "non-authorization of outpatient outpatient [sic] dx interview/psych for SCS (spinal cord stimulator) re-trial". The respondent's denial reason is supported.

2. The requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution	March , 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.